designed to elicit responses that include more than just a conclusory description of the medical services;

data forms for collecting and storing data from said patient encounter, said data comprising patient responses and user generated text information based in part on said patient encounter;

codes representative of at least one of billing, procedure, and documentation requirements;

algorithm for linking, comparing, and computing said collected data with said requirement codes; and

resultant code based in part on said linked, compared, and computed data.

91. (Amended) Apparatus for electronically calculating an appropriate United States Health Care Financing Administration (HCFA) and Centers for Medicare & Medicaid Services billing code based on a medical examination of a patient, including: electronic means for receiving information other than intermediate and final codes and automatically determining intermediate and final codes based upon said information other than those codes, said information other than those codes being sufficiently detailed to support HCFA and Centers for Medicare & Medicaid Services billing requirements.

Remarks

The claims have been amended as set forth above. As further explained below, Applicant respectfully submits that those amendments and the remarks below place the application in condition for allowance.

Preliminarily, however, Applicant notes certain typographical errors in the Remarks in his February 4, 2002 response to the Examiner's Office Action of August 2, 2001. Although the errors were clerical and apparently did not cause the Examiner any confusion or mistake, Applicant would like to remove all doubt in that regard, and accordingly notes same for the Examiner's review and consideration.

In the February 4, 2002 Amendment, the language for Claim 49 appears correctly in both the "In the Claims" and the "Version with Markings to Show Changes Made" sections. However, Claim 49 was not quoted correctly within the "Remarks" section of that Amendment. Specifically, it appears that there are typographical errors in the February 4, 2002 Amendment as follows (again, in the "Remarks" section only, not in the other "Claims" sections themselves):

- at page 12, line 18, the word "various" was omitted in the Remarks (the proper quote should have read "electronic means to repeatedly prompt for various information").
- at page 13, line 2, the phrase "description of the medical services being provided" instead should have been "medical service code based upon said underlying information".

In total, the language from Claim 49 quoted in the "Remarks" section should have read as follows (so that it would be consistent with the other two "Claims" sections of the Amendment):

"electronic means to repeatedly prompt for various information and record that information, said prompts being usable in real-time by a physician/user interacting with a patient to help guide the physician/user during said interaction with the patient and

to remind the physician/user regarding specific points of inquiry that may be relevant to further examination of that patient, said prompts soliciting underlying information regarding the details of the medical service being provided, said underlying information being usable for calculating a medical service code based upon said underlying information rather than said prompts soliciting the physician/user for the medical service code itself, said underlying information being necessary for determining and/or supporting the medical services code for purposes of the physician/user's eventual billing for the services."

As indicated above, Applicant presumes that the Examiner proceeded with his analysis of the application and claims based on the text of Claim 49 as it appeared in the "In the Claims" and "Version with Markings to Show Changes Made" sections. To the extent that presumption is not correct, Applicant expects that the Examiner will so advise.

Turning now to the Examiner's Office Action of May 21, 2002, as noted above, the Examiner's Interview Summary dated July 22, 2002 confirmed that the Office Action mailed May 21, 2002 was a non-final Office Action. Among other things, that confirmation is consistent with the Examiner's comments in the Examiner's Interview Summary faxed to Applicant's counsel on February 6, 2002, which notes that Claim 69 was "inadvertently left out in the last office action [and that] ... any future office action dealing with Claim 69 will be non-final." Since it appears that the May 21, 2002 Office Action does deal with Claim 69 (which depends from Claim 68, and, among other things, the May 21, 2002 Office Action states that "dependent claims would be allowable if overcome [sic] the 112 second rejection"), the record appears clear that the May 21, 2002 Office Action was non-final.

Applicant appreciates the Examiner's indication that Claims 51, 55, 57-59, and 68 and claims depending therefrom are allowable, subject to overcoming the

Examiner's §112 rejections. Specifically, the Examiner has rejected Claims 51, 55, 57-59 and 68 pursuant to 35 U.S.C. § 112, second paragraph, as being indefinite for failing to particularly point out and distinctly claim the subject matter which Applicant regards as the invention. Applicant has amended those claims as indicated elsewhere herein, and respectfully submits that the claims should now be allowed.

The May 21, 2002 Office Action does not appear to address pending Claims 49 or 50, other than stating on the Summary Sheet that those claims are rejected. In other words, there is no indication of a substantive basis for that rejection, and therefore no basis upon which Applicant can respond to the rejection. Accordingly, Applicant respectfully requests clarification in that regard. To the extent that the Examiner contends that those are not allowable, Applicant respectfully submits that he should be afforded an opportunity to respond to any such rejection or non-allowance in the context of a non-final Office Action.

According to Applicant's records, those now-allowable claims and the claims depending from them include (in addition to possibly Claims 49 and 50, as mentioned above), Claim 51 (and Claims 52-54 depending therefrom), Claim 55 (and Claim 56 depending therefrom), Claims 57 and 58, Claim 59 (and Claims 60-67 depending therefrom), Claim 68 (and Claims 69-73 depending therefrom), Claims 77-85 and 87-90 (depending from various other claims). Thus, in summary, Claims 49-73, 77-85, and 87-90 appear to be allowable based on the foregoing.

In addition, the Examiner has rejected Claim 91 (and Claims 92-93 depending therefrom) pursuant to 35 U.S.C. § 112, first paragraph, as based on a disclosure which is not enabling and containing subject matter which was not described in the specification in such a way as to reasonably convey to one skilled in the relevant art that the inventor(s), at the time the application was filed, had possession of the claimed invention. Applicant respectfully submits that the claims should now be allowed as well.

In that regard, Applicant notes that the HCFA (clearly set forth and supported throughout Applicant's specification) has been transitioning to a new name: "Centers for Medicare & Medicaid Services." This transition has occurred since the filing of Applicant's current application, and is documented (among other places) at websites such as http://www.hcfa.gov. To the extent that the Examiner requires some formal submission of same from Applicant, Applicant respectfully requests notice of same and an opportunity to respond and provide some such formal materials. In any case, Applicant respectfully submits that this contemporaneous change/transition by the HCFA (outside of Applicant's control) does not constitute the submission of new matter.

This is consistent with the comments in Applicant's previous Amendment. As set forth there, as of July 1, 2001, the federal agency responsible for administering many health-related programs, the United States Health Care Financing Administration (or HCFA), is now called the Centers for Medicare & Medicaid Services (CMS or CMMS) and Applicant therefore submits that HCFA (within Applicant's disclosure) is intended to and should include CMS and/or CMMS as well.

In addition, Claim 91 has been amended to address the Examiner's enablement rejection.

In view of the amendments and remarks set forth above, it is thought that the application is now in condition for allowance, notice whereof is respectfully requested of the Examiner.

Respectfully submitted,

Date: Nov. 21, 2002

J. Mark Holland

J. Mark Holland
Reg. No. 32,416
J. Mark Holland & Associates,
a Professional Law Corporation
3 Civic Plaza, Suite 210
Newport Beach, California 92660
Telephone: 949-718-6750
PTO Customer Number 21,259

JMH:LMB:ms
Enclosures

Z:\WinWord\TAMAR\P2630\2630AMD9.DOC

VERSION WITH MARKINGS TO SHOW CHANGES MADE

In the Claims:

Please amend the Claims as follows:

51. (Amended) A method for gathering a patient's data and using that data in generating a billing code, including:

providing an electronic computer to prompt an information gatherer to gather information that at least includes information relevant to calculating the billing code, said computer prompts being usable in real-time by the information gatherer interacting with a patient to help guide the information gatherer during said interaction with the patient and to remind the information gatherer regarding specific points of inquiry that may be relevant to further examination of that patient, said prompts soliciting underlying information usable for calculating a description of a~~the~~ medical service~~s~~ being provided rather than said prompts soliciting the information gatherer for the description of said~~the~~ medical service~~s~~ itself, said underlying information being independent of the description of said~~the~~ medical service~~s~~ for purposes of the eventual billing for the service~~s~~;

obtaining and recording that information;

repeating said prompting, obtaining, and recording steps; and

electronically calculating a desired billing code from said gathered data.

55. (Amended) A method of calculating a medical billing code that complies with the requirements of the United States Health Care Financing Administration, including:

providing an electronic computer or scannable form;

prompting an~~the~~ information gatherer via said electronic computer or said scannable form to gather information that at least includes information relevant to calculating the billing code, said computer prompts being usable in real-time by ~~the~~ said information gatherer interacting with a patient to help guide ~~the~~ said information gatherer during said interaction with the patient and to remind ~~the~~ said information gatherer regarding specific points of inquiry that may be relevant to further examination of that patient, said prompts soliciting underlying information usable for calculating a description of the medical services being provided rather than said prompts soliciting ~~the~~ said information gatherer for the description itself of the medical services, said underlying information being independent of the description of the medical services for purposes of the eventual billing for the services;

obtaining and recording that information into said electronic computer or said scannable form;

repeating said prompting, obtaining, and recording steps; and

electronically calculating a desired billing code from said gathered data.

57. (Amended) An integrated electronic system for conducting a medical interview of a patient and contemporaneously calculating an appropriate government billing code based on that interview, including:

electronic means for prompting an interviewer to make a series of inquiries for eliciting corresponding responses from the patient, said means optionally using at least some of the preceding responses in calculating further prompting for

inquiries to make of the patient, said means being usable in real-time by the interviewer interacting with a patient to help guide the interviewer during said interaction with the patient and to remind the interviewer regarding specific points of inquiry that may be relevant to further examination of that patient, said prompts soliciting underlying information usable for calculating a description of the medical services being provided rather than said prompts soliciting the interviewer for the description of the medical services itself, said underlying information including information independent of the description of the medical services for purposes of the eventual billing for the services;

electronic means for recording the patient's response or other information regarding the prompted inquiry; and

electronic means for calculating the government billing code based on information recorded from the medical interview.

58. (Amended) Apparatus for electronically calculating an appropriate United States Health Care Financing Administration (HCFA) billing code based on a medical examination of a patient, including:

electronic means for recording information during the medical examination, said information including at least sufficient details to support billing requirements imposed by HCFA ~~instead of just a conclusory description of the medical services~~;

electronic means for automatically determining, based upon said details, intermediate HCFA code values for sub-parts of the examination; and

electronic means for automatically determining, based upon said details, an appropriate final HCFA billing code from the intermediate HCFA code values.

59. (Amended) Electronic apparatus for use in connection with an encounter between a medical practitioner and a patient, comprising:

electronic means for prompting the medical practitioner regarding data to be obtained from the patient regarding patient care and corresponding HCFA billing codes, said data including at least sufficient details to support billing requirements imposed by HCFA, said information constituting more than ~~instead of~~ just a conclusory description of the medical services;

means for storing said data from the patient;

a menu section comprising at least one of history, physical examination, and medical decision making questions, said menu section related to said means for prompting the medical practitioner;

payer mandated requirement codes;

scores based in part on results from responses to said menu section;

algorithm for linking and processing said requirement codes with said scores; and

resultant code based in part on said linked and processed requirement codes and scores.

68. (Amended) Apparatus for compiling medical data and generating claims consistent with payer mandates, comprising:

electronic means for displaying topics of inquiry for use with a patient during a patient encounter, said topics of inquiry including at least sufficient details to support billing requirements imposed by said payer mandates, said topics of inquiry designed to elicit responses that include more than ~~instead of~~ just a conclusory description of the medical services;

data forms for collecting and storing data from said patient encounter, said data comprising patient responses and user generated text information based in part on said patient encounter;

codes representative of at least one of billing, procedure, and documentation requirements;

algorithm for linking, comparing, and computing said collected data with said requirement codes; and

resultant code based in part on said linked, compared, and computed data.

91. (Amended) Apparatus for electronically calculating an appropriate United States Health Care Financing Administration (HCFA)~~; now called~~ and Centers for Medicare & Medicaid Services~~)~~ billing code based on a medical examination of a patient, including: electronic means for receiving information other than intermediate and final codes and automatically determining intermediate and final codes based upon said information ~~in addition to~~other than those codes, said information other than those codes ~~that is~~being sufficiently detailed to support HCFA and Centers for Medicare & Medicaid Services billing requirements.